

The Delusional disorder – persecutory sub-type **the ‘recovery model’**



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A racist 'hate crime' ?

**AUSTRALIAN SUPERMACIST WHO
BURNED AND KILLED MANMEET ALISHER
BY POURING WHITE PHOSPHORUS ON HIM**



Indian PM calls Australian PM

Anthony O'Donohue

50-year-old unemployed single man

in receipt of DSP benefits

charged with one count of murder (Manmeet Sharma), arson

14 counts of attempted murder



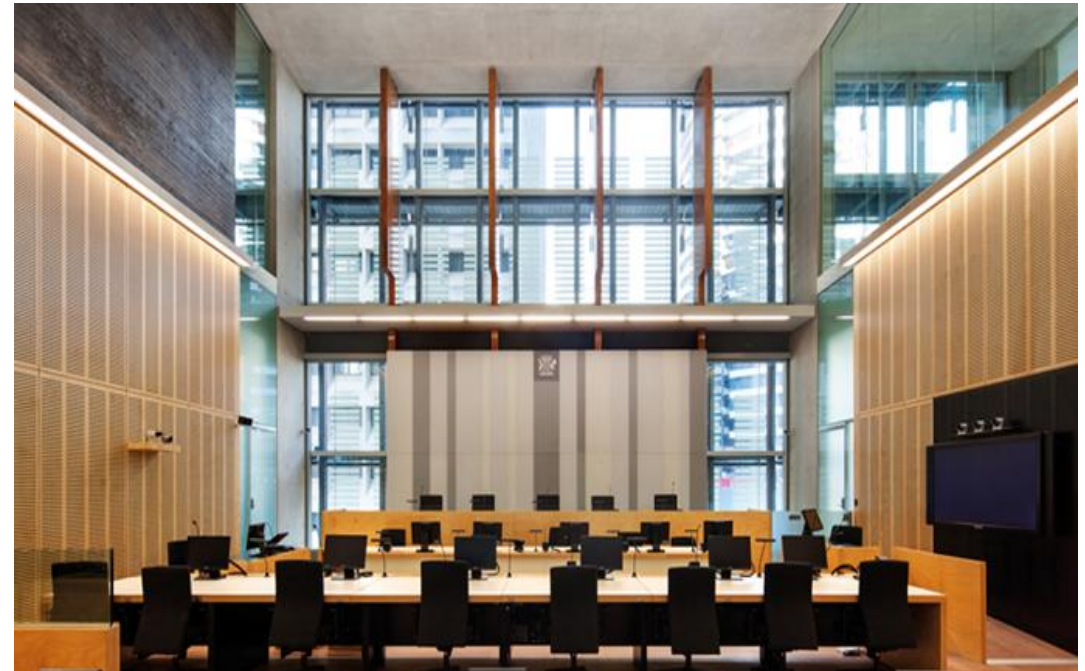
Mental Health Court, August 2018

unsound of mind, acquitted of all charges

Forensic Order

detained for treatment, secure mental health facility

for at least 10 years



Disclaimer

I have never been Mr O'Donohue's treating psychiatrist

open source material, facts widely disseminated in the media

Health Service Investigation (Mullen Review)

www.health.qld.gov.au/data/assets/pdf_file/0024/726162/mullen-review.pdf

Re Anthony O'Donohue [2018] QMHC 8 (10 August 2018)

Inquest into the death of Manmeet Sharma

Queensland Coroners Court (27 October 2023)



Anthony O'Donohue

born February 1968, caring family,

unremarkable childhood

good academic record, two university degrees

Bachelor of Agricultural Science with distinctions

mental illness – onset 2003

aged 35

employed as accountant, NSW Rail

persecutory delusions, workmates and transport “unions”

resigned, girlfriend left him

returned to Queensland, estranged from his family

First contact with mental health services, March 2010

national park in Casino, northern NSW

suicide attempt

- drank a bottle of spirits
- deliberate overdose of oxazepam

assessment by Bayside Acute Care Team

disclosed a complex delusional system

convinced he was being persecuted by

transport department employees and the “union”



Voluntary admission to Redlands Hospital mental health unit

22 March – 9 April 2010

discharge summary

- **delusional disorder – persecutory sub-type**
- prescribed oral risperidone

after discharge, **discontinued medication**, homeless

mid-2011, in a men's hostel in South Brisbane

increasingly paranoid about fellow residents, the “unions”

Violent ideation, self-presentation to police HQ, October 2011

self-presented to Queensland Police Service headquarters
thinking of attacking his tormenters
needed to be “locked up”
for his and others’ safety



Emergency Examination Order
contemplated taking a police officer’s gun
shooting people and himself
tyre lever, hammer, box cutter

Involuntary admission to RBWH, 28 October – 22 November 2011

diagnosis of delusional disorder

previously non-adherent to prescribed oral medication

commenced on depot paliperidone

discharge summary

Well-systematized delusion about unions and the public sector also involving family and friends from school ...

Socially isolated ... Poor insight and judgement ...

ITO on discharge

Follow-up with the Homeless Health Outreach Team

Risk assessment – Community Forensic Outreach Service, May 2012

engagement

strategies to appeal to his self-interest

may need a face-saving exit from the issues

all threats should be taken seriously

watch for signs of an increasing risk

- ‘last resort’ thinking, suicidal ideation
- more specific violent intent or plans

-> **treatment of the psychosis**

increase the medication

keep on the involuntary treatment order

Weapons Licensing Branch notified

Management by Metro South mental health service

October 2013, found supported accommodation in **Moorooka**
Involuntary Treatment Order transferred



New treating psychiatrist, Burke Street Clinic, 14 January 2012

new treating psychiatrist documented:

... anger about public sector unions, thoughts of being violent towards them.

... family has also turned against him.

Insight is poor ...

should remain subject to **involuntary treatment order**



6 week holiday in south-east Asia, January – March 2013

without alerting treating team, missed monthly depot
following return, attends scheduled appointments

accepts monthly depot

attends fortnightly sessions with psychologist

27 May 2013, treating psychiatrist:

Disagrees that he has a mental illness

Says he would not attend if he was a voluntary patient

Social supports limited ... thoughts of killing unionists

Insight nil ...

Declines to co-operate with a CFOS review

Burke Street clinic treating psychiatrist, 18 November 2013

*Chronic fixed delusions. 'Lack of justice' ...
fanaticizes about shooting union reps ...*

Report to Mental Health Review Tribunal, 16 December 2013

*... fixed systematized delusions, recurrent fantasies of revenge
most likely constitute ruminations ... has no plans or intent to act upon.
Poor insight into his illness, refutes this entirely ...*

Mental Health Review Tribunal, 4 August 2014

involuntary treatment order confirmed

10 week holiday in south-east Asia, October – November 2014

negotiated switch from depot injections to oral paliperidone
holiday in Thailand

on return, attended all scheduled appointments
given prescriptions for oral paliperidone

later reported since he experienced side effects

- weight gain, sexual dysfunction
- did not accept that he had a mental illness

Did not take prescribed oral anti-psychotic medication

Treating psychiatrist, 8 December 2014

Consistent themes ...

Psychological interventions seen as positive and progressing his capacity to identify emotional states.

Plan to reduce medication to deal with side effects.

... revoke Involuntary Treatment Order

Involuntary Treatment Order revoked, 16 December 2014

Engagement with Metro South mental health service

attended all monthly appointments with psychologist
attended three-monthly appointments with treating psychiatrist
always contactable by his case manager

19 December 2014, psychologist documented:

Angered by a comment from last session

... thought the psychologist had been cynical

Expressed worries about confidentiality in the public system.

It was suggested he could use the private system ...

All or nothing thinking

Uses coping strategies such as avoidance, withdrawal, rumination and alcohol abuse.

Treating psychiatrist, 9 March 2015

Consistent themes

Gets himself to sleep with repetitive fantasies of revenge (murder by shooting) upon union members at his former workplace whom he holds responsible for his professional demise and subsequent social losses.

Reduce medication (halving) to reduce side effects and due to improvements.

Treating psychiatrist, 12 October 2015

“... became enraged when discussion about future treatment raised in relation to discharge and private options.

When given timeframe of 6 – 12 months said he would suicide in 12 months. Stated he would not see a private psychiatrist.

Derogatory about mental health clinicians ... not helping, having nothing to offer, making errors of facts in his history, saying he has a mental illness.

Took script, ambivalent.

Discussed at team meeting.

Planned discharge given resistance to engaging in rehabilitation focussed treatment.

Treating psychiatrist, 15 February 2016

Re-formulated diagnoses:

“delusional disorder ... with underlying narcissistic traits”

Refuses to give permission for discussion with [general practitioner]

Quickly becomes critical with thinly veiled anger when diagnosis/symptoms/discharge discussed.

Clearly anxious re: discharge but uses denigration and criticism of [doctor] and [psychologist] for perceived faults in care and errors in documentation of his history.

Proceed with plan to discharge after two more medical reviews and reduction of [case manager] frequency and duration of visits.”

Treating psychiatrist, 18 April 2016

Remains stable. Limited social outlets.

On discussing discharge plans states 'nothing has changed. Medication has made no difference.' [accommodation] and DSP have helped more.

Has no sense of a meaningful future due to inability to adapt to the consequences of his illness ... has no insight ...

Case manager, home visit, 3 May 2016

No suicidal thoughts today ... Talked about the unions and that they are going to get what's coming to them but denies homicidal ideation.

Blew superannuation money ... two months ago.

Medical review session and then discharge planned

Discharge from the mental health service, 14 June 2016

did not attend his scheduled final clinic review

treating psychiatrist and case manager

- wrote to advise that he had been closed to the service
- recommended he seek “alternative care” through his GP

discharge summary, 1 August 2016:

Nil follow up plan as he did not give consent to correspond with GP

Burke Street clinic received phone call, 31 August 2016

- to make an appointment to see his treating psychiatrist
- advised file been closed to the Metro South mental health service

Case manager attempted phone contact, 31 August 2016

- call was unanswered
- no documentation that case manager made any further attempts
- Bourke Street clinic had no further contact

No record that general practitioner was ever identified, contacted

Did Mr O'Dnohue ever have a regular general practitioner ?

Coronial Inquest, Brisbane Magistrates Court, 14 –16 March 2022



Revocation of ITO

Case manager:

“... were no red flags.

He didn't appear to be a threat to the community ...

Treating psychiatrist:

“... after careful consideration of his progress.

He willingly co-operated with treatment, he appeared to be taking his medication, there was never any opposition to treatment.

There had been no change in his mental state, there had been no change in his risk profile ...

Based on the progress he had made, he did not require long-term case management.”



Discharge from Metro South mental health service

Was it the right decision to discharge him from the service ?

Treating psychiatrist:

“We had exhausted all other options, it was the only decision open to me at that time. We would encourage him to re-present if he was experiencing difficulties. There was nothing more we could offer him.

He refused to accept our recommendations.

He was fully informed of treatment options.

His risk to others was low, quite low.

*It was **always possible he would relapse**, he was mostly angry, not anxious, about being closed to the Metro south service.*

Purchased petrol and diesel, September 2016

kept crude incendiary materials inside his Moorooka unit

“like a loaded gun” so people who were surveilling him would know he was *“serious”* and to stop persecuting him



Fire-bombing of the Brisbane city council bus, 28 October 2016



Fire-bombing of the Brisbane city council bus, 28 October 2016

on the morning of the attack
went directly to nearby bus stop
boarded the very next bus
could not have known the bus driver
or the bus driver's ethnicity



Persecutory delusional disorder – not a ‘hate crime’



All the reporting psychiatrists confirmed

- quite disinhibited
- spoke at considerable length about his delusional beliefs
- produced hundreds of word-processed pages
- would not have been inhibited in expressing racist, bigoted beliefs

No evidence ever expressed any racist sentiments

Health Services Investigation (Mullen Review), 20 January 2017

root cause analysis

- provides structure to the retrospective examination of events
- used to uncover latent errors in high hazard organizations

designed to answer three basic questions

- what happened ?
- why did it happen ?
- what can be done to prevent it from happening again ?

clarify the connection between any flawed decision-making and a critical incident or incidents

Health Services Investigation (Mullen Review), 20 January 2017

emphasised difficulties in managing **delusional disorder**
risk of violence



Prof Paul Mullen

difficult to manage
only respond partially, at best, to medication
often resist attempts at treatment and rehabilitation

Health Services Investigation (Mullen Review), 20 January 2017

critical of the treating team's decision-making around discharge

... whilst Mr O'Donohue was apparently agreeing to discharge, his actions over those months were indicating very real anxiety about losing supports that he had relied upon for years in the context of a very limited social network and no other services involved.

Even without hindsight, discharging a long term patient without ensuring any viable transfer of care, ongoing support and treatment cannot be regarded as best practice.

Health Services Investigation (Mullen Review), 20 January 2017

critical of the treating team's decision-making around discharge

treating team made no attempt to identify, contact the GP

... not acceptable ...

'systemic issues' attributable to 'prevailing culture, practices and protocols of the Metro South Hospital and Health Service'

Mullen Review did not attribute any deficiencies to the services provided by individual health care clinicians

[The tragedy] could not have been predicted. Inevitably, had different decisions been made at certain times then the killing may not have occurred.

Health Services Investigation (Mullen Review), 20 January 2017

Summary of Findings

The investigators found that removing Mr O'Donohue from the ITO ... was based upon incomplete information.

The investigators, however, recognise there is a legal and clinical imperative to revoke an ITO when the consumer has demonstrated a willingness to comply with management on a voluntary basis, which appeared to be the situation in this case.

... 'the recovery model'

Mental Health Act 2000 (Qld)

s. 14 involuntary treatment

because of the person's illness

(i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or

(i) the person is likely to suffer serious mental or physical deterioration

and there is no less restrictive way of ensuring the person receives appropriate treatment for the illness

the person

(i) lacks the capacity to consent to be treated for the illness; or

(ii) has unreasonably refused proposed treatment for the illness

Mental Health Act (Qld)

an apparent willingness to comply, even reluctantly comply, with treatment on a voluntary basis, is not equivalent to having capacity to consent to treatment

- did not co-operate fully with the Metro South mental health service
- refused to co-operate with two CFOS assessments
- refused to accept a referral to a private psychiatrist
- refused to allow communication with any general practitioner
- refused to consent to contact with any of his friends or relatives
- declined any employment, rehabilitation or social inclusion activities
- declined to connect with any support services in the community

Risk assessment at time of revocation of the ITO

historical risk factors

past history of threatening violence

major mental illness

conflict in his previous employment

poor engagement with treatment and supervision

current clinical risk factors for future violence

no insight into his mental illness or need for treatment

symptoms of an active mental illness

recurrent violent ideation

no supports in the community

No insight into his mental illness, need for treatment

Health Services Investigation (Mullen Review), 20 January 2017

[The tragedy] *could not have been predicted. Inevitably, had different decisions been made at certain times then the killing may not have occurred.*

Law of torts, negligence, the concept of foreseeability

a foreseeable and not insignificant risk that:

- his mental state would deteriorate further
- he would not re-present to the Metro South mental health service for treatment
- he would make some kind of violent protest
- he would cause harm to himself or to a third party



Queensland Coroners Court

Mr O'Donohue's treating psychiatrist:

... there was always a risk that he would relapse after his discharge from the service.

not at risk of “**relapsing**”
psychotic illness was **never in remission.**

symptoms of his psychotic illness were never going to resolve or remit without assertive treatment.

symptoms would only have persisted or got worse.

National Framework for Recovery-oriented Mental Health Services

The 'recovery model'

'shared decision-making'

the 'dignity of risk'

the 'right to failure'

Patient autonomy

may involve 'risky and potentially self-defeating choices'

The right to dignity, respect and self-determination

-v-

The right to proper care and treatment

when the person's insight into his or her mental illness is impaired
when the person lacks decision-making capacity

never in a person's best interest to be allowed to become more unwell without treatment, particularly if there is also a risk of harm to the person or others

'engagement,' 'therapeutic alliance' and the 'recovery model'

should never detract from the right to evidence-based treatment

“GP care” -v- community mental health service case management

Australian Medical Association Position Paper, 2018

mental health disorders

12% of the total burden of disease

5.25% of the health budget

psychiatric bed occupancy is high

patients with mental illness spend longer in hospital ED

face inequality in access to health care

high re-admission rates

contribute to their poor health outcomes

“GP care” -v- community mental health service case management

Long-term evidence-based care for serious mental disorders like psychosis should properly be the primary remit of **adequately resourced public mental health services**

patients with psychotic illness

difficulty in managing attendance at appointments

anxiety, stigma in general practice waiting rooms

general practitioners

managing complex health problems

medication adherence

non-attendance for appointments

“GP care” -v- community mental health service case management

suburban general practitioners
do not have the time, resources

optimal care requires assertive case management

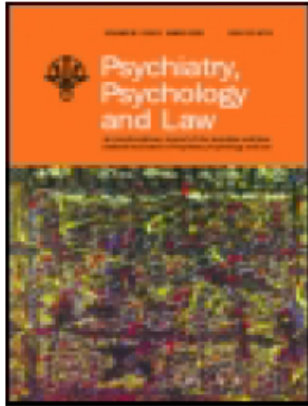
multi-disciplinary treating team

co-ordinate other services, supportive non-government organisations

survey of over 360 Australian general practitioners, 2018

- 70% reported difficulties obtaining assessment, support or treatment
- one in four said this occurred often.

“... evidence that primary care physicians are equipped, resourced and motivated to provide routine medical care to this vulnerable group is lacking.”



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